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ABSTRACT

Though many theories of the greater impact of a spouse's death on men than on women derive some support from role theory, little empirical data exist to support the hypotheses. Behavioral studies of widowhood have focused on social participation as a determinant in coping, without studying the survivor's degree of social involvement before the spouse's death. Physical response studies have focused on widow mortality rates, suggesting that men are at higher risk than women. However, these studies do not differentiate age categories when reporting results. Psychological response studies have found that, while women generally report more distress or depressive symptoms, bereaved women do not conform to this pattern. Further, existing studies do not provide any evidence to support the perception that men are more affected than women in the wake of a spouse's death. To investigate the psychological stress of death on widows and widowers, a probability sample of 163 respondents (over age 60), whose spouses had died within the last 24 months, were interviewed using the Hopkins Symptoms Checklist or the SCL-90-R and a modified version of the General Well Being Scale. An analysis of the results showed that although widows reported more symptoms, no significant gender differences were found for anxiety, somatic symptoms, or malaise. Overall, support for the perception of aging widowers as being more affected by their spouse's death is unfounded. (BL)

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AGING WIDOWS AND WIDOWERS:

DOES THE IMPACT OF BEREAVEMENT DIFFER?

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AGING WIDOWS AND WIDOWERS:
DOES THE IMPACT OF BEREAVEMENT DIFFER?

Introduction

A recent article in the New York Times began as follows:

"To mental health professionals, the face in the newspaper photographs was the class portrait of the grieving widower: eyes lowered, lips tightened, Menachem Begin was leaving a Cabinet meeting after announcing plans to resign as Prime Minister of Israel."

The article continued:

"The visible decline in Mr. Begin's health and spirits since his wife's death last November does not surprise the professionals. It is not uncommon, they say, for a powerful man to become despondent at the loss of a wife on whom he had depended for emotional support for so many years" (Dullea 1983:B12).

In a recent "Hers" column, also in the Times, New York psychiatrist Dr. Avodah Offit explained it this way:

"For most men, home is not a natural habitat after childhood. They're frequently more comfortable at the office or palling around with other men. After retirement, they often withdraw and become depressed. Women take bereavement better than men because the widow keeps her domain. The widower tends to be disoriented and so he remarries as fast as he can. Of course, there are exceptions, but this is most common" (Wilson 1983:C2).

Dr. Offit's views have been supported by some sociologists as well. Felix Berardo, writing in 1970, noted "... the consensus among some sociologists that the role of the female remains relatively unchanged upon the death of her spouse. The assumption is that a woman will continue to perform her household duties, such as cleaning and cooking and other tasks, in much the same way as when her husband was alive. Consequently, many aged widows can maintain separate living quarters and care for themselves" (Berardo 1970:15).

The situation is quite different, however, for the aging widower who is confronted with many practical problems including accomplishing additional tasks and 'traditionally female tasks.' According to Berardo, the widower is likely to need someone to prepare meals, maintain the household, and provide general care.

> At the same time, however, there is a general societal expectation that males should fend for themselves and avoid taking on a dependency status. This is an expectation which the aged widower is not always able to live up to. But his awareness of that expectation may lead to a certain hesitation or reluctance to seek assistance. In fact, in certain instances his awareness may make the widower feel compelled to sustain a public image of self-sufficiency in the face of a burdensome experience. It is quite possible that the isolation and loneliness of some widowers are the consequences of this reluctance to admit an inability to maintain a rewarding independent existence (Berardo 1970:15).

Psychiatrist Dr. Felix Post, provided the following viewpoint:

"Widowing is an event which is much more devastating than retirement. In this respect, men are in an even more

unfortunate position than women who are eventually able to re-attach themselves to other persons, especially to other widows..." (Post 1965:21).

Other explanations offered by professionals as well as the popular media to account for the greater impact of bereavement on men include the notion that men don't expect to outlive their wives and therefore are not psychologically prepared for the event (Lindsay 1983:B5). Or, "men who don't have wives to look after them are less likely to get medical care when it is needed" (Szklo 1981:A1). Or, "men are more likely to keep their emotions bottled up, not allowing themselves to go through the necessary period of grief which must precede recovery" (Lindsay 1983:B5). Or, "women may be more adaptable. They may have more of a sense of survivability" (Helsing 1981:A1).

These are some of the various explanations presumed to account for the greater impact of a spouse's death on men than on women. While many of them derive support from role theory, they are all premature --- premature in the sense that the phenomenon which they are attempting to explain has not yet been clearly established with convincing empirical evidence, particularly with regard to aging persons.

For example, the impact of the death of a spouse has been studied within the context of the stressful life events literature --- and indeed the death of a spouse has been rated one of life's most stressful events (Holmes and

Rahe 1967). However, as Gallagher and her colleagues correctly point out, "there are gaps in our knowledge." Recent reviews suggest that "... the true prevalence of psychological and physical problems in response to the loss of a spouse is not known with confidence for either sex." Moreover, "lack of knowledge is all the more evident with respect to elders who have been deliberately omitted from widowhood studies" (Gallagher et al. 1983:565). (See, for example, Glick, Weiss and Parkes 1974; Maddison and Viola 1968; Parkes and Brown 1972).

This glaring contradiction - on the one hand, widespread perceptions about aging widowers and, on the other hand, the lack of convincing empirical evidence - necessitates going back to the beginning, to examine the accuracy of the perception. Specifically, the discussion focuses on two questions: Are aging widowers more affected by a spouse's death than aging widows? Or is that a stereotypical view? Second, what evidence is there to support this perception? These two questions, while seemingly very straight-forward, are critical in view of the mental health literature. That is, there have been many studies which have clearly established that women report significantly more distress and/or depressive symptoms than their male counterparts. The consistent finding of more distress among women makes the perception about widowers even more puzzling.

In order to provide answers to these two questions, I will first turn to the literature and briefly review the

results of existing studies. Second, I will present new data from a recently completed survey of 163 bereaved older adults.

Literature Review

For clarity and simplicity, I have divided the literature into 3 categories: 1 - studies which look at behavioral responses to bereavement; 2 - studies which focus on physical responses; and 3 - studies which examine emotional or psychological reactions, often labeled mental health or mental illness studies.

Behavioral studies have concentrated on issues such as social adjustment, social interaction, social isolation, and friendship ties. An example is Berardo's study of older adults living in Thurston County, Washington. Berardo reported that the most isolated subjects in the sample were the aged widowers, especially those who were older, relatively uneducated, living in a rural environment, and in poor health. In comparison with other marital statuses, widowers were least likely to live with children, be satisfied with extended family relationships, receive from or give to children various forms of assistance, have friends or be satisfied with opportunities to be with close friends. In addition, Berardo also found that widowers were least likely to be church members, to attend church services, or belong to or participate in formal organizations or groups. Furthermore, this low degree of social participation was not due to lack of time, because the widowers reported a great surplus of leisure hours than

other marital groups.

Based on these findings of low activity levels and his reading of other studies, Berardo concluded that "... the aged male survivor encounters rather severe difficulties in his efforts to adapt to the single status; that he experiences a different impact from the loss of a spouse than that experienced by his female counterpart" (Berardo 1970:22).

Berardo's conclusion is premature because there is no indication in his study that the activity levels of widowers represents a change from previous levels. Indeed, it is conceivable that what he measured was a continuation of long established behavioral patterns or a conscious decision to change the level of involvement. In short, Berardo does not clearly establish that widowers experience more severe difficulties than widows or that the impact of a spouse's death is different for aging men and women. What he does document is that activity levels and interpersonal relations vary for men and women in different marital statuses.

A second behavioral study focused on social participation in friendship was conducted by Zena Smith Blau with 968 people over age 60 living in New York. Blau divided her sample into two age groups: young widows and widowers were those between 60 and 70; old widows and widowers were over age 70. Then she compared the percent of high friendship participation between women and men in the two age groups. She reported that 47 percent of young

widowers associated with friends compared to 53 percent of young widows. She explained the lower participation of young widowers in structural terms: that young widowers are deviant since there are so few of them in the same age group. Young widows, however, are not in a similar deviate position since they have other widows with whom to associate.

The situation is reversed, however, for those over 70. Widowers report a 67 percent participation rate presumably because there are many more widowers who can be relied on for companionship. The rate for old widows was 52 percent, about the same as for younger widows. Based on these percentages and without the use of statistical tests of significance, Blau concluded that since the loss of a spouse is especially rare for men under 70, "...widowhood has a more detrimental effect on the participation of men than on that of women" (Blau 1961:432).

Similar to Berardo, Blau's conclusions are based solely on cross-sectional data. However, it is possible that young widowers always had low participation patterns and would continue to do so even when over age 70.[1] Similarly, it is conceivable that the older widowers always had high rates of participation. Without longitudinal data, there is no way of knowing whether these participation rates reflect continuous patterns of participation or changes as a result of a change in marital status. Thus, her conclusion is also premature.

Physical Responses. The second category of studies are

those which measure what might be considered physical responses to the loss of a spouse. A major example are studies of mortality rates following the death of a spouse. In their review of these types of studies, Jacobs and Ostfeld drew several conclusions: first, there is an elevated risk of mortality associated with conjugal bereavement; second, the risk of mortality is greater for men at all ages than for women. These conclusions are basd on studies using second data sources (like vital statistics and death certificates) as well as from prospective studies (Jacobs and Ostfeld 1977).

An example of a secondary data source is the study of Kraus and Lilienfeld which relied on death certificates to compare death rates of several non-married groups with married groups. They found higher rates in the non-married groups and within the non-married category, they found higher rates for those who were widowed rather than single and divorced. Furthermore, the ratios for men exceeded those for women (Kraus and Lilienfeld 1959). In another study which used death certificates, McNeill found widowers under age 60 at greatest risk in the first 6 months and widows under age 60 at greatest risk in the second year after death. There is no indication that there were any differences in mortality rates between men and women over age 60 (McNeill 1973).

A the prospective type of mortality study, Rees and Lutkins compared 903 survivors with a matched control group. They reported that bereaved male relatives had the

highest rates of mortality and that widowers were subjected to the greatest risk, especially in the first six months (Rees and Lutkins 1967).

Finally, in the recently completed Johns Hopkins mortality study, researchers Helsing and Szklo compared death rates for widowers and married males, for widows and married females. They reported significantly higher death rates for widowers than married males and this significant difference remained after adjusting for socio-demographic characteristics. However, there were no significant differences in mortality rates of widows compared to married women after similar adjustments. In addition to the overall higher rate for widowers, when controlling for age, widowers in the 55 to 64 and 65 to 74 age groups had significantly higher rates as well (Helsing and Szklo 1981).

To summarize, while mortality studies suggest that widowers are at higher risk, the findings must be viewed with caution. For example, although the Johns Hopkins study showed higher rates for widowers, the difference was not significant for widowers over 75. Additionally, the Hopkins study did not find increased risk for widowers in the first six months but found an increased rate for many years. This latter finding contrasts with other studies which show that widowers are at high risk in the first 6 months. Thus, it is not clear from these studies that men in all age categories experience higher death rates. Nor has it been clearly established whether the period of

greatest risk for men is the the first six months after the spouse's death.

Psychological Responses. The third literature category involves studies focused on emotional or psychological responses to a spouse's death. In a study of 109 white widows and widowers interviewed within one month of the death, Clayton, Halikas, and Maurice reported that 35 percent received a diagnosis of depression. Equal percentages of men and women were depressed in the first month. The researchers noted that while affective disorders, like depression, are usually more common among women, among those with a family history of psychiatric illness, and among those previously treated for depression, they did not find any of these three characteristics among the depressed bereaved respondents (Clayton, Halikas, Maurice 1972).

In another study of 24 women and 16 men whose relatives died in the hospital, Clayton, Desmarais, and Winokur examined gender differences for 13 bereavement symptoms. On 11 of the symptoms, there were no significant differences. On 2 of the symptoms, crying and the use of medicines for nerves and/or sleep, the difference between women and men was significant with women reporting more crying and more use of medication. It is interesting that the 11 symptoms for which no differences were reported included sleep disturbance, anorexia and/or weight loss, irritability, difficulty concentrating, loss of interest in TV, news, friends, job or church, depressed mood,

self-condemnation, suicidal thoughts, somatic symptoms, and feeling tired. Thus, the authors concluded that there were no strong gender differences among bereaved relatives on most symptoms (Clayton, Desmarais, Winokur 1968).

In a recent study comparing psychological distress for 199 recently bereaved elderly rspondents with 79 non-bereaved elderly persons, Gallagher et al. found that the bereaved were significantly more distressed than the non-bereaved. However, these differences in distress were independent of gender. That is, while women reported greater distress than men, there were no gender differences within the bereaved group that could be attributed directly to the loss of a spouse. Women in both the bereaved and non-bereaved group reported higher distress (i.e. significant main effects of group and gender but no significant interaction) (Gallagher et al. 1983).

Although Gallaher's findings of no significant gender differences can only be considered suggestive (due to the low response rate of 30 percent and the possibility of response bias), they do support findings from the Duke Longitudinal Study. The Duke study consisted of a very small sample of 10 males and 23 females who were married initially and widowed during the course of the study. The respondents' mental health was measured before and after bereavement by psychiatric evaluation.[3] Of 20 women rated 'not depressed' before widowhood, 4 became 'depressed' after widowerhood. Another 3 were rated 'depressed' both before and after widowhood. This trend in the direction of

more depressed feelings for women was absent in the men. The 8 men rated 'not depressed' before widowhood continued to be rated 'not depressed.' However, 2 men rated 'depressed' before the spouse's death became 'not depressed' after widowhood.

According to the researchers, Heyman and Gianturco, the only emotional changes involved depressed feelings. There were no significant changes in ratings for anxiety or hychondriasis before or after widowhood for either men or women. Thus, they concluded that the mild increase in depressed feelings for some women after widowhood appeared to be minimal. Furthermore, bereavement did not have a major impact on emotional status, activities, or attitudes of either men or women (Heyman and Gianturco 1973).

To summarize, the mental health literature clearly supports two generalizations. First, while women generally report more distress or depressive symptoms, bereaved women do not conform to this pattern. Second, despite sample limitations or methodological problems, existing studies do not provide any evidence to support the perception that widowers are more affected than widows in the wake of the spouse's death.

Study of 163 Bereaved Older Adults

The focus now shifts to the epidemiological study which I conducted in conjunction with staff and faculty from Rutgers Medical School, University of Medicine and Dentistry of New Jersey. The data were collected in face-to-face interviews during 1980 and 1981 from a random

probability sample of 163 respondents who were bereaved within 24 months of the interview. The respondents were selected from residents living in Middlesex County, New Jersey. The County consists of several large urban centers, many suburban towns, and a large rural area. Approximately 10 percent of the total County's population (594,984) is over age 65, a proportion similar to the national average.

The sample was obtained by using obituaries published in the two major county newspapers. The name, address, and date of death of every person over age 60 who was survived by a spouse residing in the county was recorded on a daily basis. The age of 60 was selected in order to include widows and widowers who were older than the deceased and possibly over age 65. This was done for the 6 to 24 month period prior to the scheduled interview. The refusal rate was approximately ten percent. The completion rate was 53 percent. The remainder were not available for interviews for the usual reasons (e.g. not at home after three callbacks, too sick or senile, unable to locate, etc.).

Psychological distress was measured with 2 instruments: a self-report symptom scale called the Hopkins Symptoms Checklist or the SCL-90-R (Derogatis et al. 1973); and a modified version of the General Well Being Scale used by the Rand Corporation in its Health Insurance Study (Rand 1979). The SCL-90-R is considered a 'notable example' of the newer research and diagnostic instruments which are multi-dimensional and content-meaningful.

Developed during the past 10 to 15 years, it has been tested for internal consistency and scaled to represent meaningful dimensions of psychopathology (Dohrenwend and Dohrenwend 1982). It measures psychological distress by asking respondents how much they were bothered by each of 90 symptoms in the past week: not at all (0); a little bit (1); moderately (2); quite a bit (3); and extremely (4). The 90 symptoms are interpreted in terms of 9 primary symptom dimensions (depression, anxiety, somatization, etc.) and 3 global indices of distress. A decision was made to use only those scales which achieved a coefficient alpha of .80 or greater, the acceptable level for epidemiological surveys. Thus, somatization (.80), depression(.83), and anxiety (.80) along with the GSI (.95) are retained as measures of the dependent variable, psychological distress.

The second instrument used to assess distress is the General Well Being Scale used by Rand and based on the GWB Schedule developed by Dupuy for use in the National Health Interview Survey. Our modified version utilizes 15 of the items which represent both favorable and unfavorable definitions of mental health (e.g. How much of the time have you felt cheerful? How often did you get rattled or flustered?) Six response choices are offered for each item ranging from extremely positive to extremely negative evaluations. All items ask the respondents about their emotional status during the past month. The scoring for the negative items has been reversed so that all scale

items are in the same direction with low scores reflecting more positive evaluations. The reliability coefficient for this scale is .90, comparable to the .93 reported by the developer.

The SCL-90-R and the General Well Being Scale are distinct in the information they elicit. The SCL-90-R asks about specific symptoms while the Well Being Scale taps more general feeling states. The fact that the instruments are not tapping the same dimensions is reflected in the zero-order correlation coefficient of .59 for the bereaved sample. On all 5 measures of psychological distress, higher scores reflect more distress. Thus, the General Well Being scale is more aptly termed General Malaise.

Socio-demographic variables were measured using standardized questions regarding year of birth, education, income, and employment status. The interviewers recorded both the gender and race of the respondent. Regarding the treatment of the socio-demographic variables, gender, race, and marital status were coded as dummy variables for the regressions. Education, income, and age were retained in interval form for the regression analyses.

Table 1 presents the prevalence of moderate and severe distress for widows and widowers on the 5 distress measures. As shown, widows report significantly more general distress and depression symptoms in the moderate level. There are no significant gender differences for anxiety, somatic symptoms, or general malaise. With regard to severe distress, there are no significant gender

differences on any of the 5 distress measures.

Table 2 presents zero-order correlations between the 5 distress measures and socio-demographic characteristics. Again, gender is significant only for 2 of the 5 measures, general distress and depression. The positive but very minimal correlations indicate that widows are reporting more symptoms. Thus, the correlations provide support for widows' higher prevalence rates in the moderate level.

Table 3 presents multiple regression coefficients which permit examination of the relationship between gender and distress while controlling for all other socio-demographic variables. As shown, gender is not significant for any of the 5 measures. That is, the 2 modest correlations (between gender and general distress and gender and depression) disappear when all socio-demographic variables are considered simultaneously.

I have presented these findings using both bivariate and multivariate statistics in order the make an important point. If a one-to-one relationship between gender and distress is considered using bivariate statistics, then it is clear that aging widows report significantly more distress and depressive symptoms than aging widowers (Tables 1 and 2). These bivariate findings suggest that aging widows are similar to women in general in reporting more distress then their male counterparts. They certainly do not support the perception of a greater emotional impact on widowers than widows.

However, it is not sufficient to consider only the

bivariate relationship of gender and distress. If gender and distress are examined while controlling all other socio-demographic characteristics, that is, as part of a multivariate relationship, then it becomes clear that gender neither explains nor predicts any of the distress measured in this study. These findings broadly support the Duke Longitudinal Study and the work of Gallagher et al.

Conclusion

These data, along with the studies presented, allow us to answer the original question: Are aging widowers more affected by their spouse's death than aging widows? The behavioral studies indicate different patterns of social participation but do not support the perception of men as more affected by bereavement than women. The mortality studies provide tentative support for the notion that widowers in some age categories may be at higher risk than widows. However, it is not clear whether the higher risk applies to all age cohorts and particularly to those men over 75. Finally, the studies of psychological distress clearly do not provide any support for the perception about aging widowers. Indeed, the data available at this time strongly suggest that there are no gender differences. Thus, mental health professionals, sociologists, psychiatrists, and others who conclude that aging widowers are more despondent or psychologically distressed than aging widows will find little empirical evidence for their conclusions. A revision of this stereotypical perception is warranted.

NOTES

[1] In a recent study of males aged 58 to 63, Wan and Odell (1983) conclude that prior levels of social participation (along with personality characteristics) explained more variance in social participation than major role losses like retirement or widowhood.

[2] The time interval between bereavement and interview varied from 3 months to more than 36 months with a mean lapse time of 21 months. This creates a serious methodological problem because some of the bereaved were evaluated for depression right after the death while others were interviewed many months or years later. Thus, it is possible that the 4 widows rated depressed were interviewed close to the time of death whereas all of the widowers may have been interviewed more than a year later when any signs of depression may have disappeared.

TABLE 1: PERCENTAGE OF WIDOWS AND WIDOWERS REPORTING DISTRESS SYMPTOMS

A. MODERATE LEVEL OF SYMPTOMS[1]

MEASURES OF DISTRESS	WIDOWS (n=119)	WIDOWERS (n=44)	SIGNIFICANCE
GENERAL DISTRESS (GSI)	22.7 (27)[2]	6.8 (3)	CHI^2=5.388 P=.02
DEPRESSION	28.6 (34)	13.6 (6)	CHI^2=3.869 P=.05
ANXIETY	18.5 (22)	11.4 (5)	NS
SOMATIC	19.3 (23)	9.1 (4)	NS
GENERAL MALAISE[3]	26.1 (31)	25.0 (11)	NS

B. SEVERE LEVEL OF SYMPTOMS[1]

GENERAL DISTRESS (GSI)	9.3 (11)	2.3 (1)	NS
DEPRESSION	14.3 (17)	6.8 (3)	NS
ANXIETY	9.2 (11)	2.3 (1)	NS
SOMATIZATION	7.6 (9)	0 (0)	NS
GENERAL MALAISE[3]	6.7 (8)	4.6 (2)	NS

[1] Moderate symptoms defined as more than 1 standard deviation beyond the mean of the Community Sample. Severe symptoms defined as more than 2 standard deviations beyond the mean of the Community Sample.

[2] Number of respondents indicated in parentheses.

[3] General Malaise is a modified version of the Rand Health Insurance Study General Well Being Scale with the scores reversed (i.e. higher scores indicate lower level of well being or malaise).

TABLE 2: ZERO-ORDER CORRELATIONS BETWEEN DISTRESS AND DEMOGRAPHICS

	CHARACTERISTICS				
	GENDER[1]	RACE[2]	AGE	INCOME	EDUCATION
DISTRESS MEASURES					
GENERAL DISTRESS (GSI)	.18*	-.06	-.10	-.05	-.19
DEPRESSION	.17*	.06	-.07	-.09	-.15*
ANXIETY	.09	.04	-.04	-.05	-.08
SOMATIZATION	.13	-.08	.04	-.12	-.17*
GENERAL MALAISE[3]	.05	-.02	-.08	-.05	-.12

*P<=.05

[1] Gender coded 1 for male, 2 for female.
[2] Race coded 1 for Black/Hispanic, 2 for White.
[3] General Malaise is the Rand HIS General Well Being Scale reversed.

TABLE 3: REGRESSIONS OF 5 DISTRESS MEASURES UPON DEMOGRAPHIC CHARACTERISTICS[1]

	GENERAL DISTRESS	DEPRESSION	ANXIETY	SOMATIZATION	GENERAL MALAISE[2]
FEMALE (0,1)	8.72	1.59	1.12	9.29	9.08
WHITE (0,1)	-6.25	2.23	.87	-1.98	-.52
AGE (IN YEARS)	-.33	-.05	-.03	-.03	-.10
AGE X SEX	.003	.01	-.01	.15	-.12
EDUCATION (IN YEARS)	-.91	-.31*	-.12	-.20	-.46
INCOME	-.05	-.06	-.03	-.14	-.07
INTERCEPT	61.91	9.90	4.88	11.38	45.99*
R^2	.05	.06	.02	.06	.03
N	161	160	160	160	161

* P<=.05

[1] Unstandardized regression coefficients are presented. N's vary due to missing values or some variables.

[2] General Malaise is the Rand HIS General Well Being Scale reversed.

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